County of San Bernardino Department of Behavioral Health
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Name of Client: _____	Date of Birth: _____ Month/Day/Year
Sex: ☐ Male ☐ Female	Social Security: _____-_____-_____

Completion of this document authorizes the release, disclosure, and/or use of health information about you. Failure to provide all information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____ to release to:
(Facility Name/Provider/Other)

(1) Name: _____
Address: _____

Phone Number _____
Fax Number _____

a. ☐ All health information pertaining to my medical history, mental or physical condition and treatment received – *OR*

☐ Only the following records or types of health information (including any dates):
_____

b. I specifically authorize release of the following information (check as appropriate):

☐ Mental health treatment information
☐ HIV test results
☐ Alcohol/drug treatment information

Note: A separate authorization is required for use or disclosure of medical records and psychotherapy notes. See Compliance Policy 0911: Client Access and Amendment of Medical Record for the form.

PURPOSE

Purpose of requested use or disclosure: ☐ patient request; *OR* ☐ other:

_____
_____
_____
_____

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To Agencies Receiving This Information: This information is protected by state and federal laws and should not be given to anyone else not included on this Authorization without a new Authorization from the client, unless otherwise authorized by law. If you have received alcohol and/or drug assessment, treatment, or referral program information, the following applies: This information has been disclosed to you from records protected by Federal confidentiality law/rule (42 CFR, Part 2). The Federal rules forbid you from making another/any further release/disclosure of this information unless expressly/specifically permitted by the written consent of the person signing this Authorization or as allowed by Federal law/rule (42 CFR, Part 2). A general Authorization of medical or other information is NOT sufficient for this purpose. The Federal laws/rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

EXPIRATION

This Authorization expires [insert date]: _____

MY RIGHTS

I may refuse to sign this Authorization. It will not affect my ability to get treatment.

I have a right to receive a copy of this Authorization.

To the extent permitted by law, I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

I may revoke this authorization at any time, but must do so in writing and submit it to the following address:_____

_____

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization.

Information released by this Authorization could be re-released by whoever receives it, and the re-release is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

SIGNATURE

Date: _____ Time: _____ am/pm

Signature: _____
(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

_____

Witness: _____